STATE OF MICHIGAN
IN THE
SUPREME COURT

APPEAL FROM THE MICHIGAN COURT OF APPEALS

MICHIGAN CHIROPRACTIC COUNCIL, and the MICHIGAN CHIROPRACTIC SOCIETY,

Plaintiffs-Appellees,

v

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES,

Defendant-Appellant,

and

FARMERS INSURANCE EXCHANGE and MID-CENTURY INSURANCE COMPANY,

Intervening Defendants-Appellants.

Supreme Court No. 126530-1

Court of Appeals No. 241870, 241874

Ingham County Circuit Court
No. 01-93481-AA

NOTICE OF HEARING

MOTION TO FILE PROPOSED BRIEF *AMICUS CURIAE* ON BEHALF OF THE COALITION PROTECTING AUTO NO-FAULT (CPAN)

BRIEF ON APPEAL OF *AMICUS CURIAE* COALITION PROTECTING AUTO NO-FAULT (CPAN)

PROOF OF SERVICE

Date: August 12, 2005

Respectfully submitted,

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Ingham CC: 01-93481-AA

BRIEF ON APPEAL OF AMICUS CURIAE COALITION PROTECTING AUTO NO-FAULT (CPAN)

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TABLE OF CONTENTS

Page

INDEX OF AUTHORITIES iii

STATEMENT OF BASIS OF JURISDICTION v

STATEMENT OF QUESTIONS INVOLVED vi

STATEMENT OF FACTS 1

INTRODUCTION 3

ARGUMENT 6

I. MANAGED CARE OPTIONS VIOLATE § 3107(1)(a) OF THE NO-FAULT ACT 6

A. Michigan no-fault insurance is a fee for service system, not a managed care scheme 6

B. Managed care options inherently conflict with the no-fault statute, and thus, are void as against public policy 14

C. The legislature is the proper forum for deciding whether managed care options should be permissible under the no-fault system 18

D. Managed care options create a dangerous conflict of interest by unfairly empowering a no-fault insurer to shape and control the medical treatment, and thus, the evidence which will determine its responsibility to pay benefits 20

II. ASSOCIATIONS HAVE STANDING 21

CONCLUSION AND RELIEF REQUESTED 24

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INDEX OF AUTHORITIES

Page

Cases

Advocacy Org for Patients & Providers v Auto Club Ins Ass'n,
472 Mich 91 (2005) 21

Cruz v State Farm Mut Auto Ins Co,
466 Mich 588 (2002) 14, 15, 26

Cruz v State Farm Mut Auto Ins Co,
241 Mich App 159 (2000) 14

Henry v Dow Chemical Co,
____ Mich ____ (2005), Slip Opinion dated July 13, 2005 19

Hofmann v Auto Club Ins Ass'n,
211 Mich App 55 (1995) 10, 11, 12, 13

In Re Telecom Filing Requirements,
210 Mich App 681 (1995) 22

MCC v Financial & Ins Comm'r,
262 Mich App 228 (2003) 4, 19

Mercy Mt Clemens Corp v Auto Club Ins Ass'n,
219 Mich App 46 (1996) 12, 13

Morgan v Citizens Insurance Co,
432 Mich 640 (1989) 17

Munson Med Ctr v Auto Club Ins Ass'n,
218 Mich App 375 (1996) 11, 12, 13

Muskegon Building and Construction Trades v Muskegon Area Intermediate School District,
130 Mich App 420 (1983) 22, 23

Sprague v Farmers Ins Exch,
251 Mich App 260 (2002) 9

Tousignant v Allstate Ins Co,
444 Mich 301; 506 NW2d 844 (1993) 7, 8, 9

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INDEX OF AUTHORITIES - cont.

Page

White Lake Improvements Ass'n v City of Whitehall,
22 Mich App 262 (1970) 24

Statutes

MCL 418.101, *et seq* 11

MCL 500.3107(1)(a) 6

Other Authority

LeDuc, Michigan Administrative Law (1993) 24

House Bill 4742 . . . . . 5, 18

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STATEMENT OF BASIS OF JURISDICTION

Amicus Curiae CPAN does not contest this Court's Jurisdiction.

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STATEMENT OF QUESTIONS INVOLVED

I. WHETHER MANAGED CARE OPTIONS VIOLATE § 3107(1)(a) OF THE NO-FAULT ACT?

The Trial Court answered "No."

The Court of Appeals answered "No."

Appellees answer, "No."

Appellants answer, "Yes."

Amicus Curiae CPAN answers, "No."

II. WHETHER ASSOCIATIONS HAVE STANDING?

The Trial Court did not address this question.

The Court of Appeals did not address this question.

Appellants answer, "No."

Appellees answer, "Yes."

Amicus Curiae CPAN answers, "Yes."

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STATEMENT OF FACTS

This lawsuit challenges whether managed care options are valid under the no-fault insurance system in Michigan. A managed care option requires that a no-fault claimant treat only with medical providers approved by his or her no-fault insurer after being involved in a motor vehicle accident. If an insured fails to treat with an approved medical provider, he or she can be penalized under the terms of the managed care option.

A managed care option is not a form of coordinated coverage under § 3107(1)(a) of the No-Fault Act, which permits a no-fault insurer to coordinate medical benefits with "*other health and accident coverage*." It is an optional endorsement on an uncoordinated no-fault policy. It permits a no-fault insurer to utilize a managed care scheme in exchange for a reduction in premium where its no-fault coverage is primary, not secondary, to the insured's health insurance (and often managed care) plan.

Appellants offer no-fault insureds a managed care option called a "Preferred Provider Option Endorsement" or PPO option. It states in pertinent part the following:

> *"Policyholders who elect the Preferred Provider Endorsement will receive a 40% reduction on their PIP rate. The endorsement requires the insured to choose a physician from our captured network, Preferred Providers of Michigan, to manage health care in the event of a covered injury. . . . ."*

The Insurance Commissioner tacitly approved managed care options in no-fault by allowing policies containing them to be used in Michigan, including the above PPO option.

Appellees challenged the Insurance Commissioner's tacit approval of the above PPO option at an administrative hearing, but no violation was found. On appeal, the Ingham County Circuit Court invalidated the above PPO Option. The Court of Appeals

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affirmed the Circuit Court's ruling. This Court granted leave to address whether managed care options are permissible under the existing no-fault system.

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INTRODUCTION

The Coalition Protecting Auto No-Fault (" CPAN") is a broad-based group formed to preserve the integrity of Michigan's model no-fault automobile insurance system. CPAN consists of fifteen major medical groups and thirteen consumer organizations:

CPAN: Coalition Protecting No-Fault	
Medical Provider Groups	**Consumer Organizations**
Michigan Academy of Physicians Assistants	Brain Injury Association of Michigan
Michigan Assisted Living Association	Disability Advocates of Kent County
Michigan Association of Centers for Independent Living	Michigan Paralyzed Veterans of America
Michigan Brain Injury Providers Council	Michigan Partners for Patient Advocacy
Michigan Chiropractic Society	Michigan Protection and Advocacy Services
Michigan College of Emergency Physicians	Michigan Rehabilitation Association
Michigan Dental Association	Michigan Citizens Action
Michigan Health & Hospital Association	Michigan Consumer Federation
Michigan Home Health Care Association	Michigan State AFL-CIO
Michigan Orthopedic Society	Michigan Trial Lawyers Association
Michigan Orthotics and Prosthetics Association	Michigan Tribal Advocates
Michigan Osteopathic Association	Michigan UAW
Michigan State Medical Society	American Association of Retired Persons
Michigan Nurses Association	
Michigan Association of Rehab Organizations	

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Appellants, Farmers Insurance Exchange and Mid-Century Insurance Exchange ("Appellants") filed an application for leave to appeal from *MCC v Financial & Ins Comm'r*, 262 Mich App 228 (2003), which this Court granted. This case concerns whether managed care options are permissible under the existing no-fault insurance system in Michigan. Simply put, it addresses whether managed care options violate a no-fault insurer's duty to pay *"all reasonable charges incurred for products, services and accommodations for an injured person's care, recovery, or rehabilitation"* under § 3107(1)(a) of the No-Fault Act.

The Michigan Chiropractic Council and the Michigan Chiropractic Society ("Appellees") are not the only associations, organizations or individuals directly affected by the managed care options in the no-fault insurance context. CPAN, and its members, are directly affected, too, because they actively and regularly interact with the no-fault insurance system. The members of CPAN, as well as the individual patients served by them, will be significantly affected by the decision in this case.

If managed care is not rejected in the no-fault context, auto accident victims insured under no-fault policies with managed care options will be severely limited as to who can treat them. Managed care options penalize no-fault insureds if treatment is undergone with providers who do not participate in the managed care scheme. Thus, managed care often denies auto accident victims access to providers who are best suited to treat them. Similarly, providers, who are capable of treating auto accident victims, will too often be denied the chance to treat them, because they are not part of the managed care scheme.

CPAN and its members maintain that managed care options violate Section 3107(1)(a) of the No-Fault Act, and the public policy underlying its adoption in Michigan. CPAN and its members further contend that the State Legislature is the proper forum for

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deciding whether to allow managed care in the no-fault context, not the judicial branch. The fact is that this very issue is currently being considered by the State Legislature. House Bill 4742 amends § 3107(1)(a) of the No-Fault Act to permit managed care options.

CPAN and its members are also deeply concerned that without legislative consideration, the integrity and balance of the no-fault reparations system will be fundamentally jeopardized by managed care options. Such managed care options create a dangerous and inherent conflict of interest in the motor vehicle accident reparations system by unfairly empowering a no-fault insurer to shape and control medical treatment, and thus, the evidence, which will ultimately determine its responsibility to pay benefits, including not only no-fault, but also uninsured and underinsured motorist, claims.

Based upon the foregoing, CPAN requests that this Honorable Court enter an order affirming the Court of Appeals' ruling, thus leaving the issue to be addressed by the State Legislature where the propriety of allowing managed care in no-fault can be fully evaluated.

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ARGUMENT

I. MANAGED CARE OPTIONS VIOLATE § 3107(1)(a) OF THE NO-FAULT ACT.

A. Michigan no-fault insurance is a fee for service system, not a managed care scheme.

In enacting the Michigan No-Fault Act in 1973, the State Legislature clearly did not draft a statute that utilizes managed care concepts, as did other states that adopted no-fault laws during the same period. In Michigan, no-fault was designed to be a ***fee for services*** system. Appellants acknowledge this point at page 22 of their Brief on Appeal, when they correctly note that *"in 1974, **managed care did not exist in Michigan**."*

Under the No-Fault Act, insurers must pay ***personal protection insurance*** benefits (commonly called ***PIP*** benefits) on behalf of persons sustaining injuries in a motor vehicle accident, regardless of who was at fault. In addition to wage loss and domestic services, PIP benefits include "***allowable expenses***," which are payable for *"all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation."* MCL 500.3107(1)(a).

The No-Fault Act does not specifically grant insurers the authority to utilize case managers, to invoke principles of managed care, to require pre-authorization before *allowable expenses* are incurred, or to act as *"gate keepers"* when it comes to a patient's medical and rehabilitation treatment plan. Under no-fault, and with very few exceptions, auto accident victims have a legally protected right to choose their own providers.

A no-fault insurer's legal responsibility is clearly set forth in § 3105(1) and § 3107(1)(a) of the No-Fault Act, wherein the Legislature made it clear that in Michigan, no-

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fault is a *fee for services* system that guarantees ***unlimited, lifetime medical and rehabilitation care***, by adopting the following broad statutory language:

> *"**Sec. 3105. (1)** Under **personal protection insurance** an insurer is liable to pay benefits for accidental bodily injury **arising out of** the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter.*
>
> ***Sec. 3107. (1)** . . . **personal protection insurance benefits** are payable for the following:*
>
> *(a) **Allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation.** . . ."*

Based upon the statutory language, three important legal principles must be followed as to the payment of *allowable expenses.* These principles are the following:

> ***(1) The expenses must be "reasonably necessary" --***
>
> ***(2) The expenses must be "reasonable charges" --***
>
> ***(3) The injury necessitating treatment must be one "arising out of" motor vehicle involvement –***

Other than these three legal principles, there are no other statutory conditions or qualifications which limit a no-fault insurer's legal obligation to its insured. Neither of these statutory sections expressly authorize or permit a no-fault insurer and its insured to contractually convert the *fee for services* system into a managed care scheme.

In fact, the only scenario when *"managed care"* even surfaces in the no-fault setting is when a no-fault insured elects to coordinate no-fault coverage with another health insurance plan, which coincidentally happens to be available through a health maintenance organization. Respectfully, Appellants' interpretation of *Tousignant v Allstate Ins Co*, 444

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Mich 301; 506 NW2d 844 (1993) as purportedly sanctioning managed care options is clearly erroneous. See Appellants' Brief on Appeal, pp 22-24.

Contrary to Appellants' claims, there is a fundamental *"principled difference between managed care through coordinated coverage and managed care under the PPO Option"* offered by Appellants. Appellants' Brief on Appeal, p 22. When no-fault coverage is coordinated under § 3109a of the No-Fault Act, the only *insurer* ***authorized*** to carry out and enforce *"managed care"* guidelines and procedures, i.e., pre-authorizing or refusing to authorize medical services as to the insured claimant is his or her health insurer, ***not his or her no-fault insurer***.

In such cases, the no-fault insurer is not empowered to implement *"managed care;"* because its legal obligation remains unchanged: it must pay those *"allowable expenses"* under § 3107(1)(a) not otherwise offered or covered by the insured's HMO plan. In other words, when this scenario actually occurs, the no-fault insured effectively turns his or her medical coverage back into the no-fault act's *fee for services* system, which includes a *right to choose* providers. Conversely, managed care options contractually subvert the statutory obligations under the No-Fault Act by turning no-fault coverage into a managed care plan.

This Court's holding in *Tousignant* in no way suggested that § 3109a *"creates, rather than resolves, the issue of managed care's compatibility with the Act."* Appellant's Brief on Appeal, p 22. All *Tousignant* illustrated was that if the insured coordinates under § 3109a, he or she has to treat within the HMO when care is *"obtainable"* and *"available."* Section 3109a does not authorize, grant or permit a no-fault insurer to convert its statutory obligation as outlined above into managing its insured's heath care.

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This key point was recently confirmed in *Sprague v Farmers Ins Exch,* 251 Mich App 260 , 270-71 (2002), which held that in a coincidental coordinated coverage scenario under § 3109a, a no-fault insurer's duty to pay *"allowable expenses"* under § 3107(1)(a) on a *fee for services* basis remains unchanged once managed care options have been exhausted under the claimant's primary health insurance plan.

In *Sprague*, the no-fault insured elected to coordinate coverage under § 3109a, making her health insurer primary. Coincidentally, the plaintiff's health insurer happened to be an HMO. The plaintiff sought treatment from a chiropractor. The plaintiff's HMO, however, did not offer chiropractic services under its plan. The plaintiff submitted the charges to her no-fault insurer, which denied the charges taking the position that plaintiff did not seek *"obtainable"* and *"available"* treatment under her HMO. Relying on *Tousignant, supra*, the Court of Appeals held the defendant no-fault insurer was liable to pay the charges since the care the plaintiff received was not otherwise available under her HMO. In this regard, the Court stated at pages 270-271:

> *"Hence, under Tousignant and Owens a party who holds a contract containing a coordinated benefits clause is required first to utilize the health care provider for services offered by that healthcare provider, but* ***is able to seek reimbursement for 'allowable expenses' that were not contractually required to be provided by the health care provider****. MCL 550.3105, MCL 500.3107, MCL 500.3109a. In other words, because the services received by plaintiff in this case were not required by contract to be provided by PHP, they were not subject to the coordination of benefits clause. As such, the general liability provision of the act, MCL 500.3105, applies to defendant's obligation to plaintiff under the act."* (Emphasis supplied).

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Consistently, the appellate courts in Michigan have rejected and condemned efforts by no-fault insurers to unilaterally inject managed care concepts into the no-fault insurance *fee for services* system. In so doing, the appellate courts have embraced and reaffirmed the intended design of the statutory no-fault insurance *fee for services* system in Michigan.

One of the earliest appellate court cases rejecting managed care concepts was *Hofmann v Auto Club Ins Ass'n*, 211 Mich App 55 (1995). In *Hofman,* chiropractors sought payment of outstanding charges for treatment rendered to ACIA's insureds. In disputing plaintiffs' claims as to what the plaintiffs' customarily accepted for payment for x-ray services, ACIA relied exclusively on plaintiffs' claim records with Blue Cross/Blue Shield of Michigan ("BCBSM"). According to ACIA, these records established the benchmark for what plaintiffs' customarily charged. ACIA's fee schedule scheme completely ignored the unambiguous statutory mandate contained in the no-fault statute authorizing payment of all reasonable charges. In rejecting ACIA's effort, the court in *Hofmann* stated:

> *"**We find that ACIA's reasoning is flawed**.*
>
> *ACIA's reasoning is premised on the principle that BCBSM's 'payments' to plaintiffs for x-rays, as opposed to plaintiffs' 'charges' to BCBSM for those x-rays, are proper criteria to be used in determining the plaintiffs' 'customary charge' for x-rays. **This position is untenable, however, in light of the clear statutory language of § 3157**. . . . Thus, ACIA's reliance on the amount that was 'paid' by BCBSM, as opposed to the amount that plaintiffs 'charged,' is unwarranted.*
>
> *Furthermore, ACIA's position ignores the fact that the amounts that plaintiffs receive in payment from BCBSM are subject to contractual limitations, **whereas the amounts that ACIA must pay for covered medical expenses are not limited contractually**."*

Hofmann, 211 Mich App at 113 (Emphasis supplied).

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The next attempt at infusing managed care concepts into no-fault that was rejected by our appellate courts occurred in *Munson Med Ctr v Auto Club Ins Ass'n,* 218 Mich App 375 (1996). In *Munson*, ACIA sought to implement a different fee schedule scheme, this time utilizing the fee schedule used for medical expenses paid pursuant to the Worker's Disability Compensation Act, MCL 418.101 *et seq*; MSA 17.237(101) *et seq*. Judge Henry W. Saad, writing for the unanimous court in *Munson*, relied on the precise reasoning in *Hofmann, supra,* in rejecting ACIA's latest effort. Judge Saad stated:

> *"In the instant case, ACIA's proffered definition of 'customary charges' is the same one that was rejected by Hofmann, although ACIA's benchmark is broader here than it was in Hofmann. (Here, ACIA defines the benchmark as the amount that Munson received from Medicare, Medicaid, BCBSM, and arguably, worker's compensation.)* ***And, as in Hofmann, ACIA ignores the limitations placed upon Munson by the federal statutes governing Medicare and Medicaid, by the state statutes governing Medicaid and worker's compensation, and by the contractual arrangement between Munson and BCBSM. Defendant's argument therefore fails for the same reasons it did in Hofmann****."*

Munson, 218 Mich App at 385. (Emphasis supplied).

Interestingly, while rejecting ACIA's latest fee schedule scheme, Judge Saad also took the liberty to harshly criticize ACIA for attempting to implement this managed care concept into Michigan's no-fault insurance *fee for services* system, notwithstanding the will of the people that was expressed during the 1992 and 1994 elections. Judge Saad stated:

> *". . . ACIA's* ***unilateral decision*** *to reimburse Munson according to the worker's compensation* ***scheme cannot be upheld given the controlling statutory language of the no-fault act****. In 1992, ACIA sough passage of a referendum, Proposal D, which would have permitted ACIA to pay no-fault claims according to fee schedules (and which required ACIA to reduce its premiums).* ***Proposal D was soundly rejected****.*

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> *Again in 1994, ACIA attempted to obtain passage and approval of similar amendments, which would have expressly incorporated the worker's compensation fee schedules with an accompanying rollback. Again the effort was unsuccessful.* ***Despite its failure to obtain an amendment of the no-fault law, ACIA nonetheless unilaterally implemented the result it wanted. ACIA's use of criteria imposed by other statutory schemes or contractual agreements is hereby rejected as a matter of law.***"

Munson, 218 Mich at 375 (Emphasis supplied).

Finally, one last effort by ACIA to utilize fee schedules was rejected in *Mercy Mt Clemens Corp v Auto Club Ins Ass'n,* 219 Mich App 46 (1996). In *Mercy*, ACIA attempted to discover from the plaintiff what it accepted as payment from various third-party payors such as Medicare, Medicaid, worker's compensation, BCBSM, HMOs and PPOs for like-kind products, services and accommodations. It was ACIA's intended purpose to use these third-party payor fee schedules as evidence to prove a *"reasonable charge"* under § 3107(1)(a). Relying on *Hofmann,* and *Munson, supra*, the court rejected ACIA's latest scheme as being no different than its failed efforts in the past. The court in *Mercy,* stated:

> *"****Under Munson, Hofmann, Hicks, and Johnson, such information is not admissible to prove the customary charge that defendant must pay under § 3157.*** *As stated in Hofmann, supra, p 109, 'a trial court would not be justified in using amounts that are subject to third-party contractual or statutory limitations as a benchmark for determining the extent of a health-care provider's customary charge.'* ***In light of the precedent, we conclude that the circuit court did not err in finding that the information sought on discovery was not relevant to whether the amounts charged by plaintiffs met the requirements of §§ 3107 and 3157 of the no-fault act and that it was not reasonably calculated to lead to the discovery of admissible evidence****. . . ."*

Mercy, 219 Mich App at 54 - 55 (Emphasis supplied).

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To the extent, Appellants use a fixed fee schedule for payment of "allowable expenses" as part of its managed care option, this case is no different than the *unlawful* fee schedule schemes rejected in *Hofmann, Munson* and *Mercy, supra.* Clearly, fee schedules – a hallmark of managed care – ignore the No-Fault Act's requirement that all reasonable charges be paid.

As Judge Saad aptly noted in *Munson*, Proposal D, which attempted to amend the no-fault system by adding fee schedules, was soundly rejected by the voters in 1994. Appellants now seek to bypass the voters (and the State Legislature) by asking this Court to do what neither the voters nor the Legislature have done: allow managed care concepts, such as fee schedules, to be used in the existing no-fault fee for services system.

Moreover, Michigan's no-fault insurance *fee for services* system is in stark contrast with other states which have enacted no-fault laws with specific statutory provisions for managed care. These states include Colorado, Florida, Hawaii and New York. A review of the no-fault statutes in each of these four states, reveals the existence of a specific statutory scheme of managed care for motor vehicle accident victims. The fundamental distinction between these managed care systems and Appellant's PPO Option is that these systems were adopted in these states after extensive legislative debate and analysis.

In sum, managed care options clearly violate the existing no-fault insurance *fee for services* system. Accordingly, this Court should *affirm* the Court of Appeals' ruling which invalidated such managed care options under the existing no-fault system in Michigan.

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B. Managed care options inherently conflict with the no-fault statute, and thus, are void as against public policy.

A no-fault insurer and its insured cannot contract to vitiate an insurer's duty to pay no-fault PIP benefits as mandated by the No-Fault Act. Where a provision in a no-fault insurance contract conflicts with the requirements of the No-Fault Act by imposing some greater obligation on one or another of the parties, the provision is, to that extent, invalid. See *Cruz v State Farm Mut Auto Ins Co,* 466 Mich 588 (2002), wherein this Court unequivocally held that a no-fault insurer cannot unilaterally establish conditions precedent to payment of no-fault benefits, such as requiring an insured to undergo an examination under oath (EUO) when the no-fault statute has no such requirement. The same proposition is true for managed care options: the no-fault insurer cannot required treatment with approved physicians only as a condition precedent to paying no-fault PIP benefits. In short, the holding in *Cruz* is absolutely controlling here, and requires that this Court reject managed care options as not being permissible under the existing no-fault system.

As in this instance, a no-fault insurer, State Farm, successfully filed with the Insurance Commissioner a petition for approval of its policy rider that conditioned payment of PIP benefits upon its insured's submission to an examination under oath ("EUO"). The plaintiff, however, refused to submit to the EUO, taking the position that State Farm's conditional EUO was inconsistent with State Farm's duty to pay benefits mandated by the No-Fault Act. Consequently, and for that very reason, State Farm denied plaintiff's PIP benefits. *Cruz v State Farm Mut Auto Ins Co*, 241 Mich App 159, 166-67 (2000).

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Ultimately, this Court held that State Farm's EUO rider conflicted with the unambiguous mandates of the no-fault act and, therefore, was invalid as against public policy. In this regard, this Court stated:

> *"Because the insurer in this matter, State Farm Mutual Automobile Insurance Company,* ***impermissibly*** *sought to enforce the EUO* ***as a condition precedent to its duty to pay no-fault benefits****, this brought the EUO provision* ***into conflict with the requirements of the no-fault statute****. . . .*
>
> * * *
>
> *Our approach is premised on the doctrine that contracting parties are assumed to want their contract to be valid and enforceable.* ***Accordingly, we are obligated to construe contracts that are potentially in conflict with a statute, and thus void as against public policy, where reasonably possible, to harmonize them with the statute****. . . .*
>
> *Finally, to apply these rules to this case,* ***State Farm and its insured could not contract to vitiate State Farm's duty to pay benefits in a timely fashion as required by the statute****. Once 'reasonable proof of the fact and the amount of loss sustained' was received by State Farm, it had to pay benefits or be subject to the penalties. Because it is acknowledged that such proof was received, State Farm's duty to pay benefits to its insured began thirty days thereafter.* ***To the degree that the contract is in conflict with the statute, it is contrary to public policy and, therefore, invalid.***
>
> ***Accordingly, on the facts here presented, defendant's attempt to require plaintiff to submit to an EUO as a condition precedent to payment of no-fault PIP benefits was impermissible*** *and, on remand, defendant must pay the PIP no-fault benefits – including arrearages and statutorily allowed penalties."* (Citation omitted).

Cruz, 466 Mich at pp 590 and 599-601 (Emphasis supplied).

In reaching its holding, this Court first analyzed the statutory obligation of a no-fault insurer to promptly pay PIP benefits. *Id*, p 596. Specifically, § 3142(1) mandates the no-

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fault insurer to make payment of PIP benefits as loss accrues. Further, § 3142(2) mandates such payment within thirty (30) days once the insurer receives reasonable proof of the loss; overdue payments are subject to an interest penalty. Accordingly, this Court concluded that the no-fault act was clear that PIP benefits must be paid in a prompt manner. *Id.* Next, this Court acknowledged its obligation to construe contracts that are at odds with statutory mandates in a manner that renders the policy language compatible with existing public policy. *Id*, p 599. Based on this analysis, this Court held that State Farm's EUO rider was invalid and, thus, illegal. The same analysis should be applied to this case.

The holding in *Cruz*, clearly illustrates why managed care options conflict with the no-fault statute, and thus, are void as against public policy. Managed care options undisputedly conflict with the unambiguous mandate of the no-fault insurance *fee for services* system by contractually limiting statutory no-fault coverage in four respects: ***first***, instead of having access to *"reasonably necessary"* medical care under § 3107(1)(a), regardless of extent or duration, treatment is only covered under a managed care option if it is deemed *"medically necessary"* by an approved *utilization management nurse;* ***second***, instead of having access to the aforementioned "*reasonably necessary*" medical treatment, whenever the patient chooses, coverage is only available for *"pre-approved"* medical care and treatment; ***third***, instead of having the freedom of choice in getting medical care from providers of your own choosing, coverage is only available for treatment rendered by providers who are already approved; and ***fourth***, instead of paying providers a "*reasonable charge*" under § 3107(1)(a), coverage is limited to a fixed fee schedule.

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In Michigan, our appellate courts have consistently embraced the notion that the no-fault *fee for services* system is designed to protect a patient's ***freedom of choice*** with regard to selecting the medical provider who will be involved in their care and treatment. This concept of freedom of choice was recognized by this Court in *Morgan v Citizens Insurance Co*, 432 Mich 640 (1989), where the issue addressed was whether a U.S. military serviceman was entitled to be compensated by his no-fault insurer for medical services rendered to him in a non-military facility. In holding that the serviceman was entitled to choose his physicians, Justice Levin, writing for the majority stated the following:

> *"The principal question presented is whether plaintiff William Morgan's no-fault automobile insurer, defendant Citizens Insurance Company of America, is relieved of responsibility under § 3109(1) of the no-fault automobile liability act for the payment of medical expenses incurred by Morgan in a nonmilitary hospital if Morgan could have obtained the medical service without charge at a military hospital.*
>
> ***The no-fault act preserves to the injured person a choice of medical service providers.*** *Section 3109(1) does not deprive an injured person, who may be eligible to obtain service in kind in a military hospital, of such choice of medical service providers.*
>
> *The purpose of § 3109(1) is to eliminate duplicative benefits provided or required to be provided under federal or state law and thereby reduce the cost of no-fault automobile insurance. Because of differences in quality and service, medical service provided in kind by a governmental source may not be duplicative of medical service obtainable in the private sector with the no-fault medical expense benefit."*

Morgan, 432 Mich App at 643 (Emphasis supplied). To the extent that a managed care option limits an insured's ability to seek treatment only from approved medical providers, it violates *Morgan, supra,* because it limits a no-fault patient's ***freedom of choice***.

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In short, such managed care options inherently conflict with the existing no-fault insurance *fee for services* system, and thus, are void as against public policy. Accordingly, this Court should *affirm* the Court of Appeal's ruling.

C. *The legislature is the proper forum for deciding whether managed options should be permissible under the no-fault system.*

The Michigan Legislature is currently considering this issue, i.e., whether to permit no-fault insurers to offer to their insureds optional managed care endorsements. Specifically, the House of Representatives, Committee on Insurance, has passed and reported out to the entire body for consideration, House Bill 4742 ("HB 4742"). The proposal in HB 4742 actually adds a new chapter to the no-fault act, entitled *"**CHAPTER 21A MANAGED CARE**."* Like Appellants' PPO Option, it provides for among other things "preferred provider selection". HB 4742, § 2151. Similarly, it applies not only to the named insured, who selected the managed care option, but also "his or her spouse, and a relative of either domiciled in the same household." HB 4742, § 2157. Furthermore, it allows a no-fault insurer to manage care retroactively to claims already made by an insured if he or she later selects a managed care option, when it states the following:

> *"SEC. 2159. MANAGED CARE MAY BE USED ON ALL MEDICAL SERVICES PROVIDED TO AN INJURED INSURED AFTER THE SELECTION OF A MANAGED CARE OPTION, REGARDLESS OF THE DATE OF THE ORIGINAL CLAIM."*

Simply put, HB 4742 legislatively authorizes a no-fault insurer to contract with an insured to convert its status from a no-fault insurer into that of a managed care health insurer.

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In the lower court proceedings in this case, the Court of Appeals adhered to constitutional limits on its power, and simply interpreted the no-fault law, as opposed to re-writing it, and deferred this issue to the State Legislature, when the Court said at page 246:

> *"Managed care, and in particular the PPO option at issue, fundamentally alters the essential premise of Michigan no-fault insurance and is inconsistent with the no-fault act general benefit provisions.* ***Incorporating managed care into the no-fault scheme, however beneficial or desirable from a policy standpoint, cannot emanate from the innovations of insurance companies or the courts, but only from the Legislature itself.***"

MCC v Financial & Ins Comm'r, 262 Mich App 228, 246 (2003). (Emphasis supplied).

This Court has also taken great care to not over-step its constitutional mandate to interpret statutes, not write them. Just recently, this Court reiterated its role in government in its decision in *Henry v Dow Chemical Co*, __ Mich __ (2005) (Slip Opinion, dated July 13, 2005). The issue in *Henry* was whether a person may claim damages for the cost of medical monitoring of possible future manifestations of toxic disease caused by the release of an identifiable toxin. Aptly deferring the public policy question to the Legislature, this Court stated at page 4 of the slip opinion:

> ***"As a matter of prudence, we defer in this case to the people's representatives in the Legislature, who are better suited to undertake the complex task of balancing the competing societal interests at stake."***

As previously noted, other states allowed managed care options in no-fault only after extensive legislative consideration as to its ramifications for the state's no-fault system.

Consequently and without legislative authority to the contrary, the managed care options in question inherently conflicts with the existing no-fault insurance *fee for services*

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system, and thus, are void as against public policy. Based upon the foregoing, this Court should clearly affirm the Court of Appeals' ruling and leave this matter to the Legislature.

D. Managed care options create a dangerous conflict of interest by unfairly empowering a no-fault insurer to shape and control the medical treatment, and thus, the evidence which will determine its responsibility to pay benefits.

A managed care option creates an inherent and very dangerous conflict of interest within the no-fault insurance system, because it affects much more than just medical treatment options. A no-fault insurer's statutory and contractual responsibility to pay PIP benefits to its insured includes more than just *"allowable expenses"* under § 3107(1)(a). It also includes *"wage loss"* under § 3107(1)(b) or *"replacement services"* under § 3107(1)(c). A managed care option contractually grants to the insurer the power to unilaterally shape and control an insured's medical treatment and in so doing, correspondingly permits the no-fault insurers to unilateral affect the evidence which may prove whether or not the insurer owes no-fault wage loss or replacement services. Such evidence may also prove whether or not the insurer owes uninsured or underinsured motorist benefits or whether liability coverage will be paid for non-economic loss when an insured makes a negligence claim against another insured under the same policy.

The simple fact is that if the no-fault insurer can control who the insured is allowed to seek medical treatment from after a motor vehicle accident, the no-fault insurer can unilaterally shape and/or control the medical evidence in all claims related to that accident. It is important to note that this concern is not one that exists in traditional managed health care systems. With managed care health insurance plans, the only question is whether medical bills are covered and should be paid by the plan. In no-fault, a comprehensive

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system of benefits is in play, which includes payment not only of no-fault PIP benefits, but also non-economic damages, if threshold injuries are established, as well as corresponding supplemental coverages such as uninsured and underinsured motorist benefits.

Thus, there is far more than just a potential conflict of interest if managed care schemes are allowed to be injected into the existing no-fault system – there is an inherent and truly dangerous conflict of interest with insurers responsible for paying a host of benefits under a comprehensive no-fault system having permission to unilaterally shape and control the treatment, and thus, the evidence that determines whether benefits must be paid. If such a monumental change is to be made in the existing no-fault system, it should come from the State Legislature, and not by the judicial branch approving no-fault insurer's efforts to inject a managed care scheme into the current no-fault law in Michigan.

II. ASSOCIATIONS HAVE STANDING.

Recently, this Court decided *Advocacy Org for Patients & Providers v Auto Club Ins Ass'n,* 472 Mich 91 (2005). This Court described AOPP as *"an organization of health care providers and patients that principally seeks to protect the legal rights of both groups."* *AOPP*, supra, at 94. Notably, this Court did not question AOPP's standing to challenge ACIA's averaging of market data regarding the cost of a given medical service as proof of what constitutes a provider's *"reasonable charge"* under 3107(1)(a) of the act. There is no distinction between AOPP's standing, which advanced the interests of its members, and the standing of Appellees in the case at bar, not to mention CPAN as *amicus curiae* here.

The law in Michigan is well established that associations such as Appellees, as well as *Amicus Curiae* CPAN, have standing to bring actions on behalf of their interested members. Associational or representational standing is well established. The issue was

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most recently addressed in *In Re Telecom Filing Requirements*, 210 Mich App 681 (1995). The defendant argued that the two trade associations in that case, the Michigan Exchange Carriers Association and the Telephone Association of Michigan, both of which were comprised of telephone companies, lacked standing to pursue an appeal from orders of the PSC establishing filing requirements for certain telecommunication service rate alterations. The Court of Appeals rejected the defendant's position concluding that the associations possessed standing because their members had a substantial interest in the subject matter of the administrative proceeding. In this regard, the court stated at pages 691-692:

> *"The PSC contends that this Court should not address the merits of the issues raised on appeal because neither the TAM nor the MECA have standing. The PSC argues that neither association has been harmed, and notes that no individual member of either association has joined in the appeal. We disagree. Standing is a legal term used to denote the existence of sufficient interest by a party in the outcome of litigation to ensure sincere and vigorous advocacy. Standing requires a demonstration of a substantial interest that will be detrimentally affected in a manner different from the citizenry at large. House Speaker v State Administrative Bd, 441 Mich 547, 554, 495 NW2d 539 (1993).* ***We hold that appellants have standing because their members have a substantial interest in questions regarding the amount and type of information required for telecommunication rate alterations, and that their interest is affected by the PSCs decisions in a manner different from the citizenry at large.***" (Emphasis supplied).

A similar issue was addressed in *Muskegon Building and Construction Trades v Muskegon Area Intermediate School District*, 130 Mich App 420 (1983), where the Court of Appeals addressed a claim that the Muskegon Trades Council lacked standing to bring an action for injunctive relief against defendants receiving bids and/or awarding contracts

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which did not pay prevailing wage rates and fringe benefits. The plaintiff was not a labor union, but rather, an association of member trade organizations. The defendant in that case had asserted that there was a lack of standing because the plaintiff was "*clearly incapable of actually being employed by a defendant.*" *Id*, p 424. The court rejected the defendant's argument, stating at page 428:

> *"In the case sub judice, it is clear that plaintiff was organized as a representative association to enhance the political and economic power of its trade organization members and, ultimately, the individual members of these trade organizations. Clearly as in White Lake [infra], plaintiff here was organized to establish and protect the rights and interests of its members.* ***Plaintiff has a direct interest in defendant's compliance with the prevailing wage act since its existence and health is dependent upon the existence and health of its member organizations, which organizations will wither or die if they are unable to effectively protect their members.***" (Emphasis supplied).

Without question, *Telecom* and *Muskegon Trades,* supra, illustrate that standing is not determined by a party's ability to make a claim individually.

Simply put, an association's very existence is to protect and represent the interests of its members. In this case, Appellees and many of the members it serves who are not networked with Appellants have a substantial interest in the validity of Appellants' managed care options. There is no requirement that an association itself be directly injured. The fact is that standing is not determined by some reflexive application of factors like those argued by Appellants. Instead, a reasoned inquiry must determine whether the party has a *"sufficient interest" "to ensure sincere and vigorous advocacy". Telecom*, supra, at p 691.

If this were not enough, in a treatise on the subject, Professor LeDuc points out the substantial case law in Michigan permitting what he calls "*representational standing*".

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According to him, allowing associations to bring an action in a representational mode prevents needless multiplicity of lawsuits, citing *White Lake Improvements Ass'n v City of Whitehall*, 22 Mich App 262 (1970). Further, representational standing is appropriate where the litigation is within the authority of the organization, injury belongs to the represented group and is one capable of redress by the decision. Clearly, all of these factors are present here. *LeDuc, Michigan Administrative Law* (1993), § 10:13, pp 17-22.

CONCLUSION AND RELIEF REQUESTED

CPAN and its members maintain that managed care options violate § 3107(1)(a) of the No-Fault Act, because such options create an inherent conflict with the unambiguous mandate in no-fault as to payment of allowable expenses, and thus, such options are void, because they clearly violate the public policy underlying adoption of the No-Fault Act. CPAN and its members maintain further that the proper forum for deciding whether to allow an optional managed care scheme within the no-fault insurance system is in the legislature, which is currently considering this very issue as part of its debate over HB 4742.

CPAN and its members are deeply concerned that without such requisite legislative consideration, the integrity and balance of the entire no-fault reparations system will be fundamentally jeopardized by a contractually implemented managed care endorsement option. Such an option creates an inherent conflict of interest within the insurance system because it unfairly empowers an insurer to unilaterally shape and control medical treatment which can affect its statutory and contractual responsibility to pay other no-fault benefits and/or uninsured or underinsured motorists benefits.

WHEREFORE, CPAN requests that this Honorable Court enter an order affirming the Court of Appeals, leaving the issue to be properly decided by the legislature.

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Respectfully submitted,

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